Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0061	A. BUILDING: _____ B. WING _____	06/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JD NURSING & MANAGEMENT SERVICES, INC	6120 KANSAS AVE, NW WASHINGTON, DC 20011

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H 000	INITIAL COMMENTS An full survey was conducted at your agency from June 6, 2013, through 7, 2013, at your new location at 6120 Kansas Avenue, N.W. to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The findings of the survey were based on a random sample of fifteen (15) clinical records based on a census of four hundred seventy-four (474) patients and fifteen (15) personnel files based on a census of five hundred-eighteen (518) employees. Observations and interviews were conducted in the patient homes during four (4) home visits and (11) telephone calls were made to current patients.	H 000		
H 390	3915.6 HOME HEALTH & PERSONAL CARE AIDE SERVICE After the first year of service, each aide shall be required to obtain at least twelve (12) hours of continuing education or in-service training annually, which shall include information that will help maintain or improve his or her performance. This training shall include a component specifically related to the care of persons with disabilities. This Statute is not met as evidenced by: Based on record review and interview, the Home Care Agency (HCA) failed to ensure each staff had obtained at least twelve (12) hours of continuing education or in-service training annually for two (2) out of the (15) fifteen personnel records reviewed. (Staff #3 and #15) The findings include: On June 6, 2013, during a review of personnel	H 390	In-service Training will be scheduled for all PCAs. All Personnel files including contract will be checked for completeness and compliance by Personnel Coordinator. A checklist has been implemented to check for 12hr continuing education or In-service training annually from employees' Date of Hire. Files will be checked monthly.	7/8/13

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H 390	Continued From page 1 records beginning at approximately 10:50 a.m., it was revealed that there was no evidence that Staff #3 and #15 had obtained the 12 hours of continuing education or in-service training annually. During a face to face interview with the human resources representative (HRR) on June 6, 2013, at approximately 4:50 p.m., it was indicated the aforementioned documents would be sent to our agency. However the agency finally acknowledged that the aforementioned HHA's did not have the required annual 12 hours of continuing education or in-service training.	H 390		
H 411	3915.11(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE Home health aide duties may include the following: (f) Observing, recording, and reporting the patient's physical condition, behavior, or appearance; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the agency failed to ensure home health aides (HHAs) documented the patient's physical condition, behavior or appearance on the medical record for three (3) of fifteen (15) patients in the sample. (Patient #1, #3 and #14) The findings include: Review of Patient #1, #3 and #14's medical records on June 6, 2013, between 12:50 p.m. to 3:50 p.m., revealed the home health aides	H 411	All Home Health and Personal Care Aides will be instructed to fill out all portions of the Time Sheets front and back. Check all that apply, place N/A if it does not apply. Data Entry Staff will check Time Sheet for completeness; notify Office RN if Time Sheet is not complete. Staff will be called into office to complete timesheet prior to being entered into system. Home Health, PCAs will be In-service on proper filling out of all aspects of Time Sheet.	7/8/13

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H 411	Continued From page 2 (HHA's) had not consistently documented the patient's physical condition, behavior, or appearance to the agency. Further review revealed the HHA only documented the activities of daily living (ADL) tasks performed for Patient #1, 3 and #14. During a face to face interview with the administrator and director of nursing (DON) on June 6, 2013, at approximately 5:40 p.m., it was acknowledged the HHA's did not document consistently on Patient #1, #3 and #14's physical condition, behavior or appearance. Further interview revealed that the HHA's would be re-trained on how to document the patient's physical condition, behavior and appearance in the patient's medical records.	H 411		
H 450	3917.1 SKILLED NURSING SERVICES Skilled nursing services shall be provided by a registered nurse, or by a licensed practical nurse under the supervision of a registered nurse, and in accordance with the patient's plan of care. This Statute is not met as evidenced by: Based on interview and record review, the Home Care Agency (HCA) failed to ensure skilled nursing services assessed the elimination pattern during each visit in accordance with the patient's plan of care (POC) for ten (10) of fifteen (15) patients in the sample. (Patient #1, #2, #3, #4, #5, # 8, # 9, # 11, # 12 and #14) The findings include: 1. Review of Patient #1's plan of care (POC) with a certification period from February 8, 2013, through August 8, 2013, on June 6, 2013, at	H 450	Skill Nursing Services shall be provided in accordance with the Patients Plan of Care. The Medicare Coordinator will conduct an In-service with all licensed staff on correct documentation of the Plan of Care. Medicare Coordinator will check Assessment for completeness of all items prior to generating 485. Field Staff be called into office to make any needed corrections after Office RNs have reviewed paper work of assigned Field Staff.	7/8/13

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H 450	Continued From page 3 approximately 11:35 a.m., revealed that the skilled nurse (SN) was to assess the patient's elimination pattern during each visit. Review of Patient #1's, Skilled Nursing Visit Notes (SNVNs) on June 6, 2013, at approximately 12:40 p.m., revealed that the SNVN documents dated May 26, April 26, March 15 and February 22, 2013, between 12:45 p.m. to 12:50 p.m., revealed no documented evidence the SN assessed the patient's elimination pattern during the scheduled visits. 2. Review of Patient #2's POC with a certification period from May 5, 2013, through November 4, 2013, on June 6, 2013, at approximately 1:10 p.m., revealed that the SN was to assess the patient's elimination pattern during each visit. Review of Patient #2's, SNVN on June 6, 2013, at approximately 1:12 p.m., revealed that the SNVN document dated May 21, 2013, at approximately 1:15 p.m., revealed no documented evidence the SN assessed the patient's elimination pattern during the aforementioned visit. 3. Review of Patient #3's POC with a certification period from December 29, 2012, through June 29, 2013, on June 6, 2013, at approximately 1:20 p.m., revealed that the SN was to assess the patient's elimination pattern during each scheduled visit. Review of Patient #3's, SNVNs on June 6, 2013, at approximately 1:22 p.m., revealed that the SNVN documents dated May 24, April 26, March 22, February 22 and January 14, 2013, revealed no documented evidence the SN assessed the patient's elimination pattern during the	H 450	See Page 3 H450	7/8/13

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H 450	Continued From page 4 aforementioned visits. 4. Review of Patient #4's POC with a certification period from January 14, 2013, through July 14, 2013, on June 6, 2013, at approximately 1:30 p.m., revealed that the SN was to assess the patient's elimination pattern during each scheduled visit. Review of Patient #4's, SNVNs on June 6, 2013, at approximately 1:35 p.m., revealed that the SNVN documents dated April 19, March 28, February 11 and January 10, 2013, revealed no documented evidence the SN assessed the patient's elimination pattern during the aforementioned visits. 5. Review of Patient #5's POC with a certification period from February 4, 2013, through August 4, 2013, on June 6, 2013, at approximately 1:50 p.m., revealed that the SN was to assess the patient's elimination pattern during each scheduled visit. Review of Patient #5's, SNVNs on June 6, 2013, at approximately 1:55 p.m., revealed that the SNVN documents dated April 26, March 14 and February 12, 2013, revealed no documented evidence the SN assessed the patient's elimination pattern during the aforementioned visits. 6. Review of Patient #8's POC with a certification period from March 14, 2013, through September 14, 2013, on June 6, 2013, at approximately 2:10 p.m., revealed that the SN was to assess the patient's elimination pattern during each scheduled visit.	H 450	See Page 3 H450	7/8/13

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H 450	Continued From page 5 Review of Patient #8's, SNVNs on June 6, 2013, at approximately 2:15 p.m., revealed that the SNVN documents dated May 1, April 1 and March 9, 2013, revealed no documented evidence the SN assessed the patient's elimination pattern during the aforementioned visits. 7. Review of Patient #9's POC with a certification period from March 3, 2013, through September 3, 2013, on June 6, 2013, at approximately 2:20 p.m., revealed that the SN was to assess the patient's elimination pattern during each scheduled visit. Review of Patient #9's, SNVNs on June 6, 2013, at approximately 2:25 p.m., revealed that the SNVN documents dated May 15 and April 5, 2013, revealed no documented evidence the SN assessed the patient's elimination pattern during the aforementioned visits. 8. Review of Patient #11's POC with a certification period from January 5, 2013, through July 5, 2013, on June 6, 2013, at approximately 2:35 p.m., revealed that the SN was to assess the patient's elimination pattern during each scheduled visit. Review of Patient #11's, SNVNs on June 6, 2013, at approximately 2:45 p.m., revealed that the SNVN documents dated May 11, April 3 and March 12, February 7 and January 25, 2013, revealed no documented evidence the SN assessed the patient's elimination pattern during the aforementioned visits. 9. Review of Patient #12's POC with a	H 450	See Page 3 H450	

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H 450	Continued From page 6 certification period from March 30, 2013, through September 30, 2013, on June 6, 2013, at approximately 3:10 p.m., revealed that the SN was to assess the patient's elimination pattern during each scheduled visit. Review of Patient #12's, SNVNs on June 6, 2013, at approximately 3:15 p.m., revealed that the SNVN documents dated May 10 and April 19, 2013, revealed no documented evidence the SN assessed the patient's elimination pattern during the aforementioned visits. 10. Review of Patient #14's POC with a certification period from March 30, 2013, through September 30, 2013, on June 6, 2013, at approximately 3:10 p.m., revealed that the SN was to assess the patient's elimination pattern during each scheduled visit. Review of Patient #14's, SNVN on June 6, 2013, at approximately 3:15 p.m., revealed that the SNVN document dated April 13, 2013, revealed no documented evidence the SN assessed the patient's elimination pattern during the aforementioned visit. During a face to face interview with the administrator and director of nursing (DON) on June 6, 2013, at approximately 5:35 p.m., it was acknowledged that the SN had not assessed Patient #1, #2, #3, #4, #5, # 8, # 9, # 11, # 12 and #14's elimination patterns during each scheduled visit according to the POC. Further interview revealed that the nursing staff would be re-trained on how to assess and record the patient's elimination patterns on the SNVNs.	H 450	See Page 3 H450	7/8/13

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H 454	Continued From page 7	H 454	The Skill Nurse is responsible for implementing preventive and rehabilitative procedures. In-service will be given to Skill Nurses. Primary Physician office will be called by Nurse to obtain and record Clients weight from MD office after visit on clients with a diagnosis of obesity. The office RNs will review assigned staff cases with obesity and review for proper documentation. Field Staff will be notified after review and expected to come in to complete within 48hrs.	7/8/13
H 454	3917.2(d) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (d) Implementing preventive and rehabilitative nursing procedures; This Statute is not met as evidenced by: Based on interview and record review, the home care agency's (HCA)skilled nursing staff failed to provide evidence that preventive and rehabilitative nursing procedures were afforded to patients related to their health conditions, for one (1) of fifteen (15) patients in the sample. (Patient #4). The finding includes: Review of Patient #4's plan of care (POC) dated January 13, 2013, through July 14, 2013, on June 6, 2013, at approximately 1:50 p.m., revealed Patient #4 had diagnoses that included obesity, diabetes mellitus type II, hypertension, congestive heart failure, proteinuria and anemia. Review of Patient #4's Initial Health/Psychosocial Assessment Form (IH/PAF) dated October 16, 2012, on June 6, 2013, at approximately 2:15 p.m., revealed that the patient was five (5) feet, three (3) inches tall and weighed three hundred and sixty (360) pounds. Review of Patient #4's Skilled Nursing Visit Notes (SNVNs) dated April 19, March 28 and February 11, 2013, on June 6, 2013, between 2:25 and 2:30 p.m., revealed no documented evidence that the SN actually weighed Patient #4 or recorded	H 454		

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H 454	Continued From page 8 the patient's reported weight during the physical assessment. During a face to face interview with the administrator and director of nursing (DON) on June 6, 2013, at approximately 5:45 p.m., it was acknowledged at the time of the survey there was no documented evidence that the nurse actually weighed Patient #4 or recorded the patient's reported weight during the physical assessment. Further interview revealed that the POC would be updated to include instructions for the nursing staff to weigh the patient or record the patient's reported weight from the primary care physician. Also the nursing staff would be re-trained on how to weigh and document the actual or reported weight on the IH/PAF and SNVN.	H 454		
H 458	3917.2(h) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (h) Reporting changes in the patient's condition to the patient's physician; This Statute is not met as evidenced by: Based on record review and interview, it was determined the skilled nurse failed to report an injury to the right ankle sustained as a result of a fall to the patient's physician for one (1) of fifteen (15) patients in the survey. (Patient #4,) The finding includes: Review of Patient #4's Skilled Nursing Visit Note (SNVN) dated April 19, 2013, on June 6, 2013, at approximately 2:22 p.m., revealed the patient	H 458	The Nurse is responsible for keeping the physician informed and updated when there is any change of Clients condition. The In-service for Licensed staff will include but not limited to reporting changes in Patients condition. Additionally, office RN staff will review notes at time of submission for follow-up.	

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H 458	Continued From page 9 complained of pain in the right ankle after falling in the kitchen. The patient rated the pain in the ankle at five (5) on a scale of one (1) to ten (10). The SN further reported that the patient had propped the right ankle on pillows to prevent swelling. The SN instructed the patient to "call the medical doctor if pain/swelling occurs". At the time of the survey there was no documented evidence the patient's physician had been made aware by the SN in a timely manner of the aforementioned changes in Patient #4's right ankle. During a face to face interview with the administrator and the Director of Nursing (DON) on June 6, 2013 at approximately 6:04 p.m., it was acknowledged at the time of the survey there was no documented evidence that the agency's nursing staff reported an injury to Patient #4's right ankle to the patient's physician. Further interview revealed that the nursing staff would be re-trained on how to report/record changes in a patient's health status to the patient's physician in a timely manner.	H 458		
H 459	3917.2(i) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (i) Patient instruction, and evalutaion of patient instruction; and This Statute is not met as evidenced by: Based on interview and record review, the home care agency's (HCA)skilled nursing staff failed to provide evidence that instructions were afforded to patients related to their health conditions, for	H 459	Teaching is a very important part of the Nursing visit. The Field Staff will be In-serviced on documentation. Patient Education will be a part of it. Staff will be instructed, when documenting what you have taught your client, use words such as instructed, educated or taught. Be sure to indicate Client/Caregivers	7/8/13

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H 459	Continued From page 10 one (1) of the fifteen (15) patients in the sample (Patient #12). Additionally, the HCA failed to provide evidence that the instructions given were understood, for four (4) of the 15 patients in the sample. (Patient #2, #3, #10 and #12) The findings include: The agency failed to ensure training and/or the evaluation of the training had been completed as prescribed. 1. Review of Patient #2's plan of care (POC) with a certification period from May 5, 2013, through November 4, 2013, on June 6, 2013, at approximately 1:10 p.m., revealed that the skilled nurse (SN) was to assess the patient's nutritional status on each visit. Review of Patient #2's medical record on June 6, 2013, at approximately 1:13 p.m., revealed a Skilled Nursing Visit Note (SNVN) dated May 21, 2013. The document indicated that the SN instructed the patient on a low fat, low cholesterol diet, meal preparation and the effects of high cholesterol on health. The SN documented that the patient "verbalized understanding" of the aforementioned instructions. The SN however, failed to document the patient's specific level of understanding of the aforementioned health teachings. 2. Review of Patient #3's POC with a certification period from December 29, through June 29, 2013, on June 6, 2013, at approximately 1:20 p.m., revealed that the SN was to assess the patient's vital signs during each visits. Review of Patient #3's medical record on June 5, 2013, at approximately 1:24 p.m., revealed a SNVN dated April 24, 2013. The document indicated that the SN instructed the patient on signs and symptoms of hypertension, medication compliance for	H 459	Response to teaching and whether able to give adequate verbal feedback and when appropriate, return demonstration of procedures.	7/8/13

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H 459	Continued From page 11 hypertension and the need to obtain a blood pressure monitoring device to record blood pressure readings daily.The SN documented that the patient was "receptive". The SN however, failed to document the patient's specific level of understanding of the aforementioned health teachings. 3. Review of Patient #10's POC with a certification period of POC dated from December 26, 2012, through June 26, 2013, on June 26, 2013, at approximately 4:15 p.m., revealed that the SN was to assess the patient's elimination pattern. Review of Patient #10's medical record on June 6, 2013, at approximately 4:16 p.m., revealed a SNVN dated April 12, 2013. The document indicated that the SN instructed the patient on catheter care and the need to maintain infection control and to prevent the catheter tubing from rubbing against the skin causing friction and possible skin breakdown. The SN documented that the patient "verbalized understanding" of the aforementioned instructions. The SN did not however, document the patient's specific level of understanding of the aforementioned health teaching. 4. Review of Patient #12's POC with a certification period from March 30, 2013, through September 30, 2013, on June 6, 2013, at approximately 3:10 p.m., revealed that the SN was to assess and coordinate all phases of the patient's care. Review of Patient #12's medical record on June 6, 2013, at approximately 3:26 p.m., revealed a SNVN dated May 10, 2013. The document indicated that the SN instructed the patient/caregiver on home safety, prevention of stress and medication management. The SN failed to provide evidence that specific instructions were provided to the	H 459	See H 459 Pages 10 & 11	7/8/13

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H 459	Continued From page 12 patient/caregiver related to their health conditions. Additionally, the SN failed to document the patient/caregiver's specific level of understanding of the aforementioned health teaching. During a face to face interview with the administrator and director of nursing (DON) on June 6, 2013, at approximately 5:50 p.m., it was acknowledged at the time of the survey there was no documented evidence that the agency's nursing staff ensured specific training and/or that the evaluation of the training had been completed as prescribed for the aforementioned patient's. Further interview revealed that the nursing staff would be re-trained on how to accurately document training and/or the evaluation of the training in the patient's medical record.	H 459	See H 459 Pages 10 & 11	7/8/13